DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Health Care Financing
HCF 1016 (Rev. 08/05)

STATE OF WISCONSIN

WISCONSIN MEDICAID
PROVIDER SUGGESTION

The Division of Health Care Financing is interested in improving its program for providers and recipients. Providers who feel any policy or procedure stated in provider publications should be revised or who wish to suggest new policies are encouraged to submit recommendations. Providers may attach additional pages if needed. Send the completed form to:

Division of Health Care Financing
Bureau of Health Care Benefits
PO Box 309
Madison WI 53701-0309

The use of this form is voluntary and providers may develop their own form as long as it includes all the information on this form.

SECTION I — PROVIDER INFORMATION

Name — Provider	Wisconsin Medicaid Provider Number

Address — Provider

Suggestion

SECTION II — PUBLICATION INFORMATION (IF APPLICABLE)

Title, Number, and Date Published — Publication

Question / Problem

Suggestion

Reset Form